

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01130

1141

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY SOMERSET		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND		b. COUNTY SOMERSET		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PRINCESS ANNE		c. LENGTH OF STAY IN 1b LIFE TIME		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X PRINCESS ANNE,				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS RT 2 BOX 291		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First WOOD	Middle	Last BAILEY	4. DATE OF DEATH	Month I	Day 16	Year 1958	
5. SEX MALE	6. COLOR OR RACE COLORED	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/19/ 1883	9. AGE (In years last birthday) 74 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0 Min. Address	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABOR		10b. KIND OF BUSINESS OR INDUSTRY SAW MILL		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME HENRY BAILEY				14. MOTHER'S MAIDEN NAME SARAH WATERS				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 217-30-8854		17. INFORMANT RUSHA BAILEY PRINCESS ANNE, MARYLAND				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 605X DUE TO Chronic Cystitis INTERVAL BETWEEN ONSET AND DEATH 3 years								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic Bronchial Asthma								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) —	(County) —	(State) —
21. I certify that I attended the deceased from May 15, 1954 to June 16, 1958 , that I last saw the deceased alive on June 14th, 1958 , and that death occurred at 10 A.M. from the causes and on the date stated above.								
ADDRESS (Street, city or town, state) Princess Anne, Maryland								
DATE SIGNED —								
ACTUAL SIGNATURE Eldore G. M. Mankinman								
PHYSICIAN'S NAME (Type) —								
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 1/19/58	22c. NAME OF CEMETERY OR CREMATORIAL MT. ZION	22d. LOCATION (City, town, or county) POLK	22e. (State) MARYLAND				
23. FUNERAL DIRECTOR'S SIGNATURE —				24a. REC'D BY REGISTRAR June 28 '58	24b. REGISTRAR'S SIGNATURE Rehse			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

RECEIVED

BUREAU U. S.

JAN 20 1959

RECEIVED

01131

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Somerset		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Princess Anne		c. LENGTH OF STAY IN 1b 13 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Princess Anne		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) Anna		First	Middle	Last	4. DATE OF DEATH Jan. 25	Month	Day	Year
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 4-15-1893	9. AGE (In years last birthday) 64 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none	10b. KIND OF BUSINESS OR INDUSTRY none	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A
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13. FATHER'S NAME Jacob Long	14. MOTHER'S MAIDEN NAME Hester Derhamer
--	--

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO.	17. INFORMANT Miss Jeannette Bellinger Pr. Anne, Md.	Address
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Cardiovascular-renal		INTERVAL BETWEEN ONSET AND DEATH years
442X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		
DUE TO (c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>

20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)				
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	

21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
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ACTUAL SIGNATURE <i>R. H. Johnson</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED January 27, 1958
EXAMINER'S NAME (Type) R. H. Johnson, M.D.	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		

22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF T-29-58	22c. NAME OF CEMETERY OR CREMATORIAL Arlington National Cemetery	22d. LOCATION (City, town, or county) Arlington, Va.	(State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>Levin R. Wilson</i>	ADDRESS Princess Anne, Md.	24a. REC'D BY REGISTRAR DATE JAN 29 '58	24b. REGISTRAR'S SIGNATURE <i>Albert E. Smith</i>	

RECEIVED STATE OF HAWAII - DEPARTMENT OF
MEDICAL EXAMINER'S OFFICE

BUREAU V.

JAN 29 1959

RECEIVED

INSTRUCTIONS

1 TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 24 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01132

CERTIFICATE OF DEATH

Reg. Dist. No.

1143

1. PLACE OF DEATH

COUNTY SOMERSETCITY (If outside corporate limits, write RURAL
OR end give nearest town)TOWN DEAL ISLANDHOSPITAL OR
INSTITUTION OR
STREET ADDRESS

AT HOME

MARYLAND

LENGTH OF STAY
(In this place)LIFE

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE MARYLANDCOUNTY SOMERSET

CITY (If outside corporate limits, write RURAL and give nearest town)

OR
TOWN DEAL ISLANDSTREET
ADDRESSMAIN

(If rural give location)

ROAD3. NAME OF
DECEASED
(Type or Print)JOHN

(Middle)

T. BENNETT

(Last)

4. DATE (Month)

OF DEATH

JAN

20

(Day)

19

58

5. SEX

MALE6. COLOR OR
RACEWHITE7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify)MARRIED

8. DATE OF BIRTH

MARCH-18-1873

9. AGE less birthday

84

IF UNDER 1 YEAR

Months

IF UNDER 24 HRS.

Days Hours Min.

10e. USUAL OCCUPATION (Give kind of work
done during most of working life, even if
retired)WOOD-OIL DEALER10b. KIND OF BUSINESS
OR INDUSTRYWholesale OIL

11. BIRTHPLACE (State or foreign country)

MARYLAND12. CITIZEN OF WHAT
COUNTRY?U.S.A.

13. FATHER'S NAME

JOHNBENNETT

14. MOTHER'S MAIDEN NAME

Virginia JONES15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unk.)

(If Yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

218-34-9565A

17. INFORMANT & ADDRESS

EMMA WEBSTER-DEAL ISLANDMD.

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331X IMMEDIATE CAUSE

(A)

Cerebral vascular accident

36 days

ANTECEDENT CAUSE(S) DUE TO

DISEASES OR CONDITIONS, IF ANY, (B)

GIVING RISE TO THE ABOVE CAUSE

STATING UNDERLYING CAUSE LAST. DUE TO

(C)

generalized arteriosclerosis

years

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING DEATH.

19e. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES NO 21e. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)21b. PLACE (Home, farm, factory,
OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED
While Not while
at work at work

21f. HOW DID INJURY OCCUR?

M.

22. I hereby certify that I attended the deceased from 12-14-57, 19....., to 1-20-58, 19....., that I last saw the deceasedalive on 1-20-58, 19.....and that death occurred at 11 AM,

from the causes and on the date stated above.

SIGNATURE
Everett C. Sutter
Everett C. Sutter MD

ADDRESS (Street, city, town, state)

DATE SIGNED

1-23-58

23. BURIAL, CREMATION,
REMOVAL (SPECIFY)

DATE THEREOF

1/23/58

NAME OF CEMETERY OR CREMATORIUM

St. John's

LOCATION (City, town or county)

Deal Island

(State)

24. REC'D BY REGISTRAR

REGISTRAR'S SIGNATURE

DATE

JAN 27 '58Alt. Sutter

25. FUNERAL DIRECTOR'S SIGNATURE

L. S. Webster

ADDRESS

Deal Island

(State)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1144 CERTIFICATE OF DEATH

Reg. Dist. No. 01133

1. PLACE OF DEATH a. COUNTY SOMERSET		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CRISFIELD		c. LENGTH OF STAY IN 1b 11 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION EDW. W. McCREADY MEMORIAL HOSP.		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) DAISY		First DAISY	Middle BRITTINGHAM
4. DATE OF DEATH JANUARY 10 1958		Lost	Month Day Year
5. SEX FEMALE		6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH AUGUST 9, 1885		9. AGE (In years lost birthday) 72 yrs	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME HENRY HENDERSON	
14. MOTHER'S MAIDEN NAME AMANDA MERRILL		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO.		17. INFORMANT FRANCIS BRITTINGHAM, WESTOVER, MD.	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Neuritis Acut Disq Nerv		INTERVAL BETWEEN ONSET AND DEATH 3 days	
(b) Cervical Infection, R. Neuroj DUE TO Pulmonary Infection			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260x General Arterio Sclerosis. Double needles.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Dec. 30, 1957 to Jan. 10, 1958 , that I last saw the deceased alive on Jan. 9, 1957 , and that death occurred at 7:57 AM from the causes and on the date stated above.		ADDRESS (Street, city or town, state) MARION STATION, MARYLAND	
ACTUAL SIGNATURE George C. Coulbourn		DATE SIGNED 1/10/58	
PHYSICIAN'S NAME (Type) GEORGE C. COULBOURN, M.D.		MARION STATION, MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-12-58	22c. NAME OF CEMETERY OR CREMATORIAL Colesbury Cemetery
22d. LOCATION (City, town, or county) Colesbury, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Levin R. Wilson, Princess Anne		ADDRESS Levin R. Wilson, Princess Anne	24a. REC'D BY REGISTRAR DATE JAN 14 '58
		24b. REGISTRAR'S SIGNATURE Levin R. Wilson	

RECEIVED
BUREAU V. S.
JAN 14 1958

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

011134

1145

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY

Somerset

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Princess Anne

c. LENGTH OF STAY IN 1b
86 yrs.

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)

a. STATE

Maryland

b. COUNTY

Somerset

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Princess Anne, Md.

d. STREET ADDRESS

e. IS RESIDENCE
ON A FARM?YES NO 3. NAME OF
DECEASED
(Type or print)First
RobertMiddle
F.Last
Duer4. DATE
OF
DEATH
Jan.Month
5
Year
1958

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

Male

White

WIDOWED DIVORCED

Aug. 23, 1871

9. AGE (In years
last birthday)
86

yrs.

10. IF UNDER 1 YEAR

11. IF UNDER 24 HRS.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

Lawyer

Law

Princess Anne, Md.

U.S.A.

13. FATHER'S NAME

Edward F. Duer

14. MOTHER'S MAIDEN NAME

Virginia White

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

E. McMaster Duer, Jr., Anne

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

177X

DUE TO

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause last.

(b)

DUE TO

(c)

Bronchopneumonia

Carcinoma of prostate c metastasis

INTERVAL BETWEEN
ONSET AND DEATH

6 month.

19. WAS AUTOPSY PERFORMED? YES NO

491X

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a. m. 19
p. m.20d. INJURY OCCURRED
While
at work Not while
at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from May 1957 to Jan 5, 1958, that I last saw the deceased alive on 1-4-58, and that death occurred at 2:00 A.M. from the causes and on the date stated above.

ACTUAL
SIGNATUREPHYSICIAN'S
NAME (Type)ADDRESS (Street, city or town, state)
Salisbury, Md.DATE SIGNED
1-5-5822a. BURIAL, CREMATION, REMOVAL (Specify)
Burial22b. DATE THEREOF
1/7/5822c. NAME OF CEMETERY OR CREMATORIAL
St. Andrews Cem.22d. LOCATION (City, town, or county)
Princess Anne, Md.

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

24a. REC'D BY REGISTRAR
DATE JAN 10 '5824b. REGISTRAR'S SIGNATURE
Reverend

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **011135**

1. PLACE OF DEATH a. COUNTY		1146		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
Somerset		MARYLAND		a. STATE Maryland b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Westover Md		Life		Westover Md.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS	

3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
Algie				Handy	JANUARY	15		1958

5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH	9. AGE (in years from birthday) yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.
Male	Colored		About 1869	89	Months	Days

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer	Rail Road	Maryland	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MARRIED NAME
William Handy	Amelia - ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
No		Dorothy Dashfield	Westover Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		8-18 hrs
932.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		
DUE TO (b)		
freezing weather		
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Lived alone in Shack No Fire-		

20c. TIME OF INJURY	Month, Day, Year	20d. INJURY OCCURRED	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
7 Hour o. m. p. m.	Jan 15 1958	While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> of work <input checked="" type="checkbox"/> at work <input type="checkbox"/>	Home	Westover	Somerset	Md.

21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>						
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ACTUAL SIGNATURE	R. H. Johnson	DATE SIGNED
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EXAMINER'S NAME (Type)	R. H. Johnson	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>
		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>

22a. FUNERAL CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORIAL	22d. LOCATION (City, town, or county)	(State)
Funeral	1/20/58	St James	Westover	Md.

23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
William H. Johnson	Funeral Home	JAN 24 '58	W. E. Lee

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, signing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

— a *Y-shaped* *verb* *group* *with* *two* *verb* *heads* *and* *one* *complement* *group*

18 P-31 1400A 1000-1200-1300-1400-1500

K2 U 11519-01A 60119 7-7-06-1

✓ - S. 300A. V. B. R. E. T. T. M. 11/11/1971

Xi Shufang has died.

75010001 115000

— or a 12632 in state board

BUREAU V.

JAN 24 1958

PREGELEIV EDO

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01136

Reg. Dist. No.

1147

1. PLACE OF DEATH a. COUNTY Somerset MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE Maryland b. COUNTY Somerset				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Princess Anne - RFD		c. LENGTH OF STAY IN 1b Life time		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Princess Anne - Rural Rt. 1 (Mt. Vernon)				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print)		First Sarah	Middle Gale	Last Harris	4. DATE OF DEATH January 8, 1958	Month January	Day 8	Year 1958
5. SEX Female	6. COLOR OR RACE Col.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 3, 1900		9. AGE (In years last birthday) 77 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor			10b. KIND OF BUSINESS OR INDUSTRY oyster shucker		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Gale			14. MOTHER'S MAIDEN NAME Annie Waters					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT John Gale - Rt. 1 - Princess Anne, Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 491X Bronchial Pneumonia of both rt. and left 5 days DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) upper lobes of the lungs. DUE TO (c) Diagnosis made after autopsy								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Mt. Vernon	(County) Somerset Co., Md.	(State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>								
ACTUAL SIGNATURE <i>R. H. Johnson</i>		DATE SIGNED January 14, 1958						
EXAMINER'S NAME (Type) R. H. Johnson, M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/14/58	22c. NAME OF CEMETERY OR CREMATORIUM St. Paul		22d. LOCATION (City, town, or county) Mt. Vernon - Somerset Co., Md. (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>William H. James Jr.</i>		ADDRESS Princess Anne, Md.	24a. REC'D BY REGISTRAR JAN 16 1958		24b. REGISTRAR'S SIGNATURE <i>W. H. Johnson</i>			
		DATE						

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

WEDDING EXAMINER'S CERTIFICATE OF DEATH
WEDDING STATE EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

JAN 16 1928

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

01137

1. PLACE OF DEATH a. COUNTY <i>Somerset</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Somerset</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Crisfield</i>	c. LENGTH OF STAY IN 1b <i>Life</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>39 Crisfield</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>At Home - Main St.</i>		d. STREET ADDRESS <i>Main St.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>WILLIAM H. LOWE SR</i>	First	Middle	Last
4. DATE OF DEATH <i>JAN 2</i>	Month	Day	Year <i>1958</i>
5. SEX <i>Male</i>	6. COLOR OF RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec. 23 - 1890</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Waterman</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Seafood</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>WILLARD F. LOWE</i>	14. MOTHER'S MAIDEN NAME <i>HATTIE PARKS</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>214-16-4341</i>	17. INFORMANT <i>William Lowe Jr - Crisfield</i>	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>malignant hypertension</i> DUE TO <i>445X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arteriosclerosis -</i> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Hour a. p. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Jan 1</i> , 1958, to <i>Jan 2</i> , 1958, that I last saw the deceased alive on <i>Jan 1</i> , 1958, and that death occurred at <i>2:30 PM</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <i>David M. Payton</i> M.D. <i>3341 Main St - Crisfield</i> <i>Jan 2 1958</i> PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial Jan 4 1958</i>	22b. DATE THEREOF <i>Jan 4 1958</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Sunnyridge Memorial</i>	22d. LOCATION (City, town, or county) <i>Crisfield Md.</i> State
23. FUNERAL DIRECTOR'S SIGNATURE <i>Webster Crisfield</i>	ADDRESS <i>10 Webster Crisfield</i>	24a. REC'D BY REGISTRAR DATE <i>JAN 10 '58</i>	24b. REGISTRAR'S SIGNATURE <i>Releasueh</i>

CERTIFICATE OF DEATH

WITNESSED

BUREAU V. S.

JAN 10 1959

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1148

CERTIFICATE OF DEATH

01138

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY somerset		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Princess anne		b. COUNTY Somerset	
c. LENGTH OF STAY IN lb LIFE TIME		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x PRINCESS ANNE MARYLAND	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First HOWARD	Middle SAMUEL	Last MORRIS
4. DATE OF DEATH	Month I	Day 28	Year 1958
5. SEX Male	6. COLOR OR RACE COLORED	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/12/1884
9. AGE (In years last birthday) 73 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BARBOR	10b. KIND OF BUSINESS OR INDUSTRY SELF EMPLOYED	11. BIRTHPLACE (State or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME ALBERT MORRIS		14. MOTHER'S MAIDEN NAME HENNETTA GRAY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT WILLIAM H. JAMES JR PRINCESS ANNE, MARYLAND
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic cystitis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) Chronic cystitis	
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Aug 27</u> , 1957, to <u>Jan 26</u> , 1958, that I last saw the deceased alive on <u>Dec 25</u> , 1958, and that death occurred at <u>4:00 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) ELDON G. MARKMAN, M.D., PRINCESS ANNE, MARYLAND DATE SIGNED <u>1-28-58</u>			
ACTUAL SIGNATURE ELDON G. MARKMAN		PHYSICIAN'S NAME (Type)	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/30/58	22c. NAME OF CEMETERY OR CREMATORIAL John Wesley
22d. LOCATION (City, town, or county) PRINCESS ANNE, MARYLAND		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE WILLIAM H. JAMES JR		24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE DATE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

WIRGINIA STATE DEPARTMENT OF HEALTH-PUBLICHEALTH

BUREAU V. 5

IAN 29 1968

REGELY ED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1138

CERTIFICATE OF DEATH

Reg. Dist. No.

11139

1. PLACE OF DEATH a. COUNTY Somerset MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield		c. LENGTH OF STAY IN 1b 33 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 417 Myrtle St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ROSA	First ROSA	Middle SERGEANT	Last PARKS
4. DATE OF DEATH January 18,	Month January	Day 18	Year 1958
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH July 10, 1868
8. AGE (In years last birthday) 89	9. IF UNDER 1 YEAR Months 0 Days 0	10. IF UNDER 24 HRS. Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) Dames Quarter, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry Clay McCoy		14. MOTHER'S MAIDEN NAME Leah A. Todd	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Clarence Todd, Crisfield, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO 331X			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) Cerebral arteriosclerosis DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1, 1958 , to Jan 18, 1958 , that I last saw the deceased alive on Jan 10, 1958 , and that death occurred at 10 a.m. M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Sarah M. Peyton		ADDRESS (Street, city or town, state) 3311 Main St., Crisfield, Maryland	
PHYSICIAN'S NAME (Type) Sarah M. Peyton, M. D.		DATE SIGNED 1/19/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-20-58	
22c. NAME OF CEMETERY OR CREMATORIUM Sunnyridge Cemetery		22d. LOCATION (City, town, or county) (State) Crisfield, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons, Crisfield, Maryland		24a. REC'D BY REGISTRAR DATE JAN 21 '58	
		24b. REGISTRAR'S SIGNATURE Alfred C. Schick	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U. S. BUREAU

JAN 21 1963

REGIV ED

1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
1139 CERTIFICATE OF DEATH 01140

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Somerset			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield		
c. LENGTH OF STAY IN 1b 13 Years			d. STREET ADDRESS Asbury Section		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Asbury Section			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) WALTER KOONTZ RICE			First WALTER	Middle KOONTZ	Last RICE
4. DATE OF DEATH January 12	Month January	Day 12	Year 19 58		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH May 30, 1903	9. AGE (In years last birthday) 54	IF UNDER 1 YEAR IF UNDER 24 HRS. Months 54
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Proprietor	10b. KIND OF BUSINESS OR INDUSTRY Bakery (Wholesale)	11. BIRTHPLACE (State or foreign country) Middleport, Ohio	12. CITIZEN OF WHAT COUNTRY? U S A		
13. FATHER'S NAME Elbert H. Rice			14. MOTHER'S MAIDEN NAME Evelyn Keontz		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 277-10-9287	17. INFORMANT Mrs. Doris H. Rice—Crisfield, Maryland	Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Myocardial Infarction			INTERVAL BETWEEN ONSET AND DEATH Few minutes		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO Coronary Insufficiency			One year		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m.		Month Jan	Day 11	Year 1958	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>
					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) June 11, 1953, 9 A.M.
					20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan 8, 1958 to Jan 12, 1958 , that I last saw the deceased alive on Jan 11, 1958 , and that death occurred at 9:30 A.M. from the causes and on the date stated above.					
ADDRESS (Street, city or town, state) M.D. 530 W. Main St. Crisfield, Md.					
DATE SIGNED 1/14/58					
ACTUAL SIGNATURE A. N. Barr					
PHYSICIAN'S NAME (Type) Dr. A. N. Barr, M. D.					
Main St.—Crisfield, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 15, 1958	22c. NAME OF CEMETERY OR CREMATORIUM Sunnyridge Cemetery	22d. LOCATION (City, town, or county) Crisfield, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons—Crisfield, Md.			ADDRESS	24a. REC'D BY REGISTRAR JAN 17 '58	24b. REGISTRAR'S SIGNATURE Alleson

CERTIFICATE OF DEATH

Deceased	Male	White	White
Male	1929	White	White
White	White	White	White
1917	NOTE	1917	1917
40	May 30, 1903	1917	1917
40	Deceased (Name)	Deceased	Deceased
Deceased	Deceased	Deceased	Deceased
53-10-287	53-10-287	53-10-287	53-10-287

FBI WILSON COUNTY

JAN 17 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01141

FOR STATE
HEALTH DEPT.

Reg. Dist. No.

1149

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Somerset		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westover		c. LENGTH OF STAY IN 1b Lifetime	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rural, Westover		e. STREET ADDRESS Rural	
3. NAME OF DECEASED (Type or print) COULBOURNE		First ROSS	Middle RUARK
4. DATE OF DEATH January 21, 1958	Month January	Day 21	Year 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH July 4, 1929
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) Kingston, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Frank Ruark		14. MOTHER'S MAIDEN NAME Vivian Elizabeth Ross	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-26-3449	
17. INFORMANT Frank Ruark, Westover, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 9141		INTERVAL BETWEEN ONSET AND DEATH Sudden	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		Electrocution Accidental	
DUE TO (c)		Contact between television antenna and overhead electric wire.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) William H. Coulbourn, M. D.	
20c. TIME OF INJURY Hour 6:15 a. m. p. m. Jan 21, 1958		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Farm		20f. (City or town) Eden, Somerset, Md.	
(County) Somerset County, Md.		(State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE William H. Coulbourn		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) William H. Coulbourn, M. D.		DATE SIGNED 1-24-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-24-58	
22c. NAME OF CEMETERY OR CREMATORIAL Salem Methodist		22d. LOCATION (City, town, or county) Pocomoke City, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons, Crisfield, Maryland		24a. REC'D BY REGISTRAR Dee	
ADDRESS		24b. REGISTRAR'S SIGNATURE JAN 28 '58	

RECEIVED JAN 28 1958
FBI BUREAU WASH. D. C.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01142

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Somerset		1150 MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PRINCESS ANNE, MARYLAND		c. LENGTH OF STAY IN 1b LIFE TIME		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PRINCESS ANNE, MARYLAND.R F D #3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First DANIEL	Middle	Last SMITH	4. DATE OF DEATH I 27 1958	Month	Day Year
5. SEX MALE	6. COLOR OR RACE COLORED	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/8/1892		9. AGE (In years 65 from birthday) yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABOR		10b. KIND OF BUSINESS OR INDUSTRY FARM		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JEFFERSON SMITH		14. MOTHER'S MAIDEN NAME SALLIE STOCKLEY					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT JAMES SMITH PRINCESS ANNE, MARYLAND.RT #3		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.2		DUE TO Chronic Myocarditis				INTERVAL BETWEEN ONSET AND DEATH 8 years	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.		(b) DUE TO					
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) VENTON	(County)	(State)
21. I certify that I attended the deceased from <u>July 10, 1952</u> to <u>Jan 27 1958</u> that I last saw the deceased alive on <u>Jan 27, 1958</u> , and that death occurred at <u>7:30 P.M.</u> from the causes and on the date stated above.						ADDRESS (Street, city or town, state) PRINCESS ANNE, MARYLAND	
ACTUAL SIGNATURE ELDON G. MARKMAN						DATE SIGNED JAN 29 '58	
PHYSICIAN'S NAME (Type) ELDON G. MARKMAN				PRINCESS ANNE, MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/30/58	22c. NAME OF CEMETERY OR CREMATORIAL GRACE	22d. LOCATION (City, town, or county) VENTON	22e. (State) MARYLAND			
23. FUNERAL DIRECTOR'S SIGNATURE William H. Jaques Jr. Princess Anne		ADDRESS	24a. REC'D BY REGISTRAR DATE JAN 29 '58	24b. REGISTRAR'S SIGNATURE D. L. Smith			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar, or to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

CERTIFICATE OF DEATH

MISSOURI

BUREAU V. S

JAN 29 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1151

CERTIFICATE OF DEATH

Reg. Dist. No.

01143

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the physician or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filled with the registration or to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY SOMERSET		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY SOMERSET	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CRISFIELD		c. LENGTH OF STAY IN lb 67 YRS.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 39 CRISFIELD			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION EDW. W. McCREADY MEMORIAL HOSP		d. STREET ADDRESS 1 FOURTH STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First HARLAN	Middle Keeler	Last STERLING	4. DATE OF DEATH JANUARY 8	Month 1958	Day 19	Year 58
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 9, 1890	9. AGE (In years last birthday) 67	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PLUMBER		10b. KIND OF BUSINESS OR INDUSTRY Plumbing		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM STERLING				14. MOTHER'S MAIDEN NAME HESTER WYATT			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-12-1833		17. INFORMANT WILLIAM R. STERLING, CRISFIELD, Md.		Address 206 SOMERSET AVE	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)							
INTERVAL BETWEEN ONSET AND DEATH 2 days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 6, 1958 , to Jan 8, 1958 that I last saw the deceased alive on Jan 8, 1958 , and that death occurred at 2:00 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE C. G. Rawley				ADDRESS (Street, city or town, state) CRISFIELD, MARYLAND			
DATE SIGNED 1958							
PHYSICIAN'S NAME (Type) DR. C. G. RAWLEY		CRISFIELD, MARYLAND					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-10-58		22c. NAME OF CEMETERY OR CREMATORIUM Sunnyridge Cemetery		22d. LOCATION (City, town, or county) Crisfield, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons, Crisfield, Maryland				24a. REC'D BY REGISTRAR JAN 13 '58		24b. REGISTRAR'S SIGNATURE Alfred J. Deucher	

DEPARTMENT OF HEALTH-PALESTINE

CEMETRIES OR GRAVES

BUREAU V.

JAN 13 1953

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar, or to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1152

CERTIFICATE OF DEATH

Reg. Dist. No.

01144

1. PLACE OF DEATH a. COUNTY SOMERSET		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY SOMERSET					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CRISFIELD		c. LENGTH OF STAY IN 1b 3 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MT. VERNON		d. STREET ADDRESS					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION EDW. W. McCREADY MEMO. HOSP.				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) FRANK		First	Middle	Last THOMAS	4. DATE OF DEATH JANUARY 17 1958	Month	Day	Year			
5. SEX MALE		6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 29, 1879	9. AGE (In years lost birthday) 78 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours	Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMING		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME JOSEPH THOMAS		14. MOTHER'S MAIDEN NAME MARY E. MASON									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT BAILEY THOMAS, MT. VERNON, MD.		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Tuberculosis acute Del of Heart INTERVAL BETWEEN ONSET AND DEATH 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) Chronic myocarditis chronic sub acute (c) General arteritis arteriosclerosis Years											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Hour o. m. — p. m. —		Month 19	Year	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —	20f. (City or town) —	(County)	(State)			
21. I certify that I attended the deceased from Jan 1 1958 to Jan 17 1958 , that I last saw the deceased alive on Jan 17 1958 , and that death occurred at 4:05 P.M. from the causes and on the date stated above.										ADDRESS (Street, city or town, state) Marion Station, Md.	DATE SIGNED George C. Coulbourn
ACTUAL SIGNATURE George C. Coulbourn										PHYSICIAN'S NAME (Type) GEORGE C. COULBOURN, M.D.	MARION STATION, MARYLAND
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/20/58		22c. NAME OF CEMETERY OR CREMATORIAL Monocacy Presbyterian		22d. LOCATION (City, town, or County) Princess Anne Md.		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE James Palmer Princess Anne Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE JAN 23 '58		24b. REGISTRAR'S SIGNATURE Asst. Ed. 1958					

THE STATE OF HAWAII - SOUTHERN DISTRICT COURT

CERTIFICATE OF DEATH

BUREAU Y.

JAN 23 1958

RECEIVED

1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

81145

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Somerset</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Mt. Veron Md.</i>		c. LENGTH OF STAY IN 1b <i>Life</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Princess Anne R.F.D.</i>		e. STREET ADDRESS <i>Princess Anne R. F. D.</i>	
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Van</i>	Middle <i>Eugene</i>	Last <i>Trader</i>
4. DATE OF DEATH	Month <i>January</i>	Day <i>24</i>	Year <i>1958</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Col.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>November 26, 1957</i>
10b. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>		11b. KIND OF BUSINESS OR INDUSTRY <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		13. FATHER'S NAME <i>Vaughn Trader</i>	
14. MOTHER'S MAIDEN NAME <i>Cynthia Gale</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	
16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Cynthia Gale, Princess Anne, R.F.D.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>491X</i> DUE TO <i>Bronche pneumonia</i> INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>R. H. Johnson</i>		DATE SIGNED M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> January 25, 1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL 1/25/58 at Zion</i>		22b. DATE THEREOF <i>1/25/58</i>	
22c. NAME OF CEMETERY OR CREMATORIAL LOCATION (City, town, or county) <i>Zion</i>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>William H. Johnson, Princess Anne</i>		24a. REC'D BY REGISTRAR ADDRESS <i>2082181 XV 6</i>	
		24b. REGISTRAR'S SIGNATURE <i>Alt. Search</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, entering the word "pending" in pencil in Item 1b. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Office of Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial or removal.

RECEIVED - CERTIFICATE OF DEATH
MICHIGAN STATE DEPARTMENT OF HEALTH

BUREAU X-8

JAN 28 1953

RECEIVED

01146

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
1154 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Somerset		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE Maryland		b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Marion Station		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Marion Station - Rt. 1 - Box 393			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			

3. NAME OF DECEASED (Type or print)	First James	Middle Henry	Last Ward	4. DATE OF DEATH January 19, 1958
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5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH July 31, 1904	9. AGE (In years from birthday) 53 yrs.	10. UNDER 1 YEAR Months Days	11. UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seafood Worker for self	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) White Stone, Virginia	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13. FATHER'S NAME James Henry Ward, Sr.	14. MOTHER'S MAIDEN NAME Sadie Nickens
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 214-18-4828	17. INFORMANT Lillie Mae Ward - Marion Station, Maryland
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 days
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>					
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ACTUAL SIGNATURE <i>R. H. Johnson</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED Jan. 21, 1958
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EXAMINER'S NAME (Type) R. H. Johnson, M.D.	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
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22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/21/58	22c. NAME OF CEMETERY OR CREMATORIAL John Wesley	22d. LOCATION (City, town, or county) Marion Sta., Md., Som Co.
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23. FUNERAL DIRECTOR'S SIGNATURE <i>Charles H. Walsh</i>	ADDRESS Marion Sta., Md.	24a. REC'D. BY REGISTRAR Jan. 22, 58	24b. REGISTRAR'S SIGNATURE <i>W. L. French</i>
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WEDNESDAY, SEPTEMBER 23, 1958
MEDICAL EXAMINER'S CERTIFICATE OF DEATH
STATE OF NEW YORK

BUREAU V.

IAN 23 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1140

CERTIFICATE OF DEATH

Reg. Dist. No. 11147

1. PLACE OF DEATH a. COUNTY Somerset		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield		c. LENGTH OF STAY IN 1b Lifetime	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Asbury Ave. (Box 257)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First DAISY	Middle STERLING	Last WILSON
4. DATE OF DEATH	Month January	Day 13	Year 1958
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 4, 1880
9. AGE (In years lost birthday) 77 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine Operator	10b. KIND OF BUSINESS OR INDUSTRY Garment Mfg.	11. BIRTHPLACE (State or foreign country) Baltimore, Md.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Luther Sterling	14. MOTHER'S MAIDEN NAME Mary Ellen Sterling		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? [Yes, no, or unknown] No	16. SOCIAL SECURITY NO.	17. INFORMANT Horace Ned Wilson—Asbury Ave.—Crisfield, Md.	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and, (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Inferior Mesenteric Thrombosis DUE TO 451X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) Dissecting Aneurysm DUE TO Unknown (c) Arteriosclerosis			
INTERVAL BETWEEN ONSET AND DEATH 14 hours			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerosis Heart Disease and Parkinsonism			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 8, 1957 to June 13, 1958 , that I last saw the deceased alive on June 12, 1958 , and that death occurred at 4:15 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>A. N. Barr, M.D.</i>	M.D.	ADDRESS (Street, city or town, state) <i>Crisfield, Md.</i>	DATE SIGNED <i>1/14/58</i>
PHYSICIAN'S NAME (Type) Dr. A. N. Barr, M. D.	Main St.—Crisfield, Md.		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jan. 16, 1958	22c. NAME OF CEMETERY OR CREMATORIUM Sunnyridge Cemetery	22d. LOCATION (City, town, or county) (State) Crisfield, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons—Crisfield, Md.		24a. REC'D BY REGISTRAR DATE JAN 17 '58	24b. REGISTRAR'S SIGNATURE <i>W. L. Leisch</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After his certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with
the registrar to burial, cremation, or removal, and in any event within 72 hours after death.

Fig. 1. η^+ and η'

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DREAU & CO.

JAN 17 1959

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